

<b>Case Number:</b>	CM14-0156529		
<b>Date Assigned:</b>	09/26/2014	<b>Date of Injury:</b>	12/04/2008
<b>Decision Date:</b>	01/13/2015	<b>UR Denial Date:</b>	09/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/24/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 68 year old female with an injury date of 12/04/08. Based on the 06/20/14 progress report, the patient complains of right shoulder pain with increasing pain isolated to the area under the deltoid. This pain is accompanied with weakness. The 07/30/14 report states that the patient rates her pain as a 7-8/10. Muscle strength testing on forward-flexion and abduction is 4/5. The 09/09/14 report indicates that the patient would "like to go forward with surgery for her right shoulder because of her limited range of motion and her continued pain." The deltoid is modestly atrophied. No further positive exam findings were provided. The patient's diagnoses include the following: Right shoulder adhesive capsulitis Right rotator cuff repair and revision repair Right shoulder biceps tenodesis-failed The utilization review determination being challenged is dated 09/23/14. There were four treatment reports provided from 03/05/14-09/09/14.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**MRI Right shoulder w/o contrast:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Magnetic resonance imaging (MRI)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 207-208.

**Decision rationale:** According to the 09/09/14 report, the patient presents with right shoulder pain, with increasing pain to the area under the deltoid. The request is for an MRI RIGHT SHOULDER WITHOUT CONTRAST for consideration of a right reverse shoulder arthroplasty. Review of the reports does not provide any prior MRIs of the right shoulder the patient may have had. ACOEM Guidelines has the following regarding shoulder MRI on pages 207-208, "Routine testing (laboratory test, plain film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first 6 weeks of activity limitation due to shoulder symptoms, except when a red flag noted on history or examination raise a suspicion of a serious shoulder condition or referred pain." ACOEM Guidelines page 207-208 continue to state that the primary criteria for ordering imaging studies include: 1.) emergence of red flags; 2.) physiologic evidence of tissue insult; 3.) failure to progress in strengthening program; and 4) clarification of anatomy prior to an invasive procedure. ODG Guidelines under shoulder chapter supports MRI of the shoulder if conservative measures have failed and rotator cuff/labral tear are suspected. In regards to the right shoulder, the patient has a limited range of motion and per 09/09/14 report, the patient would "like to go forward with surgery for her right shoulder." The treater is requesting for this MRI of the right shoulder in consideration of a right reverse shoulder arthroplasty. The request is in accordance with ODG guidelines. The requested MRI of the right shoulder is medically necessary.

**Self direct aquatic therapy (1) year:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy; Physical Medicine Page(s): 22, 99. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Physical Therapy

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Physical Medicine Page(s): 98-99, 22.

**Decision rationale:** According to the 09/09/14 report, the patient presents with right shoulder pain, with increasing pain to the area under the deltoid. The request is for SELF DIRECT AQUATIC THERAPY, 1 YEAR for strengthening of her upper extremities particularly the right shoulder. Review of the reports does not mention if the patient has had any prior aquatic therapy. MTUS Guidelines, page 22, CHRONIC PAIN MEDICAL TREATMENT GUIDELINES: Aquatic therapy "Recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. For recommendations on the number of supervised visits, see Physical medicine. Water exercise improved some components of health-related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities may be required to preserve most of these gains. (Tomas-Carus, 2007)" MTUS Guidelines, pages 98-99, CHRONIC PAIN MEDICAL TREATMENT GUIDELINES: Physical Medicine "Physical Medicine Guidelines - Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home

Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. In this case, the treater does not indicate how frequently the patient will be attending aquatic therapy throughout the year nor does the treater explain why the patient cannot complete land based therapy. None of the reports mention if the patient is extremely obese and there is no discussion as to why the patient requires weight-reduced exercises. There is no discussion regarding treatment history as well to determine how the patient has responded in the past. The patient should be able to do whatever form of exercise necessary to manage chronic pain. However, the requested "self-direct aquatherapy" is non-specific. The requested aquatic therapy is not medically necessary.

**H-Wave Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave stimulation (HWT).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HWT) Page(s): 117-118.

**Decision rationale:** According to the 09/09/14 report, the patient presents with right shoulder pain, with increasing pain to the area under the deltoid. The request is for H-WAVE UNIT. The 09/09/14 report states that the patient "has previously had a trial of an H-wave that was effective in temporarily reducing her pain." Per MTUS Guidelines, "H-wave is not recommended as an isolated intervention, but a 1-month home-based trial of H-wave stimulation may be considered as a non-invasive conservative option for diabetic, neuropathic pain, or chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration and only following failure of initially recommended conservative care." MTUS further states trial periods of more than 1 month should be justified by documentations submitted for review. Prior TENS unit failure is required as well. In this case, the request is for a purchase. Although the 09/09/14 report states that the patient had trial of an H-wave that was "effective in temporarily reducing her pain," the treater failed to provide any documentation of this trial to show that the patient had any benefit. There is no evidence that a 30-day trial has been successful. It is unknown when the patient had this trial or how the H-wave trial impacted the patient. There is no documentation that the patient has failed prior TENS unit. The request is not medically necessary.